

Prevention: A Shared Commitment

Making the case
for a Prevention
Transformation Fund

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Foreword

We should put our faith in the old adage that ‘prevention is better than cure’, and yet, as a nation we spend a relatively small amount of money on it.

About 5 per cent of the entire healthcare budget is spent on prevention. Local Government Association (LGA) research on a range of local prevention schemes suggests that investment in prevention could yield a net return of 90 per cent.

The current social care and health system is unsustainable and will buckle under the weight of demand unless we re-engineer our planning and service provision to promote healthy choices, protect health, prevent sickness and intervene early to minimise the need for costly hospital treatment. Trying to fix this by focusing on treatment alone is not the answer. We need preventative strategies that mitigate or defer the need for costly interventions and at the same time deliver better outcomes for individuals.

Local government has been unanimous in our support for taking leadership of public health and working with our local partners to achieve shared priorities. We really do think we can make a difference to the lives of our local population by helping them live longer, healthier and lead more fulfilling lives, but only if we do things differently and are resourced appropriately.

This paper has sought to identify, and pull together, key pieces of evidence about the cost effectiveness of prevention in order to develop the LGA’s concept of a Prevention Transformation Fund.

A Prevention Fund, delivered upfront for new local prevention services, could prevent problems arising in the first place, prevent dependency on the health and social care system, or – when targeted at the right groups of people – prevent the escalation of problems which become worse for individuals and more costly to the taxpayer.

The health needs of the future – especially patients with long-term conditions – and the challenge of closing a growing funding gap means that we can’t go on with business as usual.



Councillor Izzi Seccombe
Chair, Community Wellbeing Board

Background

In the 21st century, a huge part of the burden of ill health is avoidable. About a third of all deaths are classed as premature – that is they could have been prevented by lifestyle changes undertaken at an earlier time of life. That equates to 44 years of lost life per 1,000 people or 2.6 million years each year across England and Wales.

In 2013, approximately 22.5 per cent (106,537 out of 473,552) of all deaths registered in England were from causes considered avoidable through good quality healthcare or wider public health interventions.¹

It is estimated by the World Health Organization (WHO) that almost one third of the disease burden in industrialised countries can be attributed to four main behaviours: smoking, alcohol intake, fruit and vegetable consumption, and lack of physical activity.²

But when considering the cost of that illness it is not just the bill for the treatment and care that should be taken into account. The economic consequences of premature death and preventable illness are considerable too. These can include loss of productivity in the workplace and the cost of crime and antisocial behaviour.

Dame Carol Black's review of the health of the working-age population in 2008 estimated that the annual cost of sickness absence is more than £100 billion a year.³

Two thirds of adults and a quarter of two to 10 year olds are overweight or obese. Treating the consequences of obesity costs £5.5 billion to the health and social care system and has significant impacts on the quality of lives of people.⁴

The proportion of adults who are overweight or obese is predicted to reach 70 per cent by 2034.⁵

Alcohol-related crime accounts for about 920,000 violent incidents each year – accounting for 47 per cent of violent offences committed.⁶ The total annual cost to society of alcohol-related harm is estimated to be £21 billion. The NHS incurs £3.5 billion a year in costs related to alcohol.⁷

Trips and falls cost the NHS more than £2 billion each year, with a 35 per cent increase in acute care costs in the year following a fall.⁸

Loneliness and social isolation are as damaging to our health as smoking 15 cigarettes a day.⁹

1 Avoidable Mortality in England and Wales, 2013 ONS
2 WHO, Global Burden of Disease Study, 2010
3 Working for a healthier tomorrow: work and health in Britain, 2008

4 Making the case for tackling obesity - why invest? February 2015

5 Making the case for tackling obesity - why invest? February 2015

6 Crime Survey for England and Wales, CSEW, 2012

7 Alcohol treatment in England 2013-14 PHE

8 Local action on health inequalities: Understanding the economics of investments in the social determinants of health, 2014

9 Campaign to end loneliness/threattohealth

Examples of the estimated overall annual costs for society are:



If this avoidable ill-health could be reduced the savings would be considerable. However, the funds available for prevention are limited. We spend around 20 times as much on treating ill health as we do on direct prevention, yet the relative cost-effectiveness equation sees a reversal of these proportions – primary prevention is likely to be 24-40 times more cost-effective than treatment on a lifetime basis, with a break-even point after as little as two years.

“... [The] future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health.”

The NHS Five Year Forward View, October 2014

A relatively modest investment away from treatment to prevention could help to realise a disproportionate benefit in improved population health and averted costs to the NHS, health system and wider society.

An approach advocated by the All-Party Parliamentary Group on primary care and public health’s report on its inquiry into the sustainability of the the NHS (July 2013).

There has been significant amount of evidence produced over recent years to show the cost – effectiveness of prevention.

In 2011, National Institute Clinical Excellence in Health and Care (NICE) analysed 200 public health interventions ranging from smoking cessation to exercise on prescription. Their effectiveness was compared against a control. This included measures such as the background quit rate for smoking interventions, standard treatments or in some cases no intervention at all. Thirty were found to be cost-saving, 141 were deemed good value for money.

In 2008 the Matrix Knowledge Group and Bazian were commissioned by the Department of Health to look at the issue of cost effectiveness. They analysed 41 different programmes and highlighted several areas that should be prioritised for investment, including smoking cessation, school-based programmes for obesity prevention and falls prevention for the elderly. Another source of evidence is the supporting documents produced by government to accompany policy papers.

10 Cost of Diabetes. Diabetes UK

11 Cough up: balancing tobacco income and costs in society

12 Alcohol Harm Reduction Strategy for England

13 Health – third report

14 Start active, stay active: a report on physical activity from the four home countries’ Chief Medical Officers.

For example, the 2011 cross-government strategy, 'No Health without Mental Health', included an economic case paper setting out the available evidence on a host of interventions.

It cited research which showed alcohol screening and counselling by GPs had the potential to save the NHS and criminal justice system £40 million a year each, while parenting interventions aimed at those most at risk were estimated to save £9,288 per child over 25 years.

A strong case was put for investing more in prevention as long ago as 2002 when the Wanless Report estimated that effective public health policy which leads to high levels of public engagement in terms of their health could be saving the NHS £30 billion a year by 2022-23.

'Enabling Effective Delivery of Health and Wellbeing', an independent report produced by Sir Howard Bernstein, Dr Paul Cosford and Alwen Williams in 2010, made the case that extra investment in preventative action could help the country prosper and flourish in light of the economic hardships being experienced.

More recently, the health regulator Monitor published a report, 'Closing the NHS funding gap: how to get better value healthcare for patients' which said investment in public health along with greater innovation in clinical care was the key to helping keep the NHS sustainable in the long-term.

In America, the Obama Administration established the 'Prevention and Public Health Fund' to provide expanded and sustained national investments in prevention and public health, to improve health outcomes, and to enhance health care quality. To date, the Fund has invested in a broad range of evidence-based activities including community and clinical prevention initiatives.

"If the nation fails to get serious about prevention then recent progress in healthy life expectancies will stall, health inequalities will widen, and our ability to fund beneficial new treatments will be crowded-out by the need to spend billions of pounds on wholly avoidable illness."

**The NHS Five Year Forward View,
October 2014**

Making the case for a Prevention Transformation Fund

The past five years have been characterised by councils finding innovative ways to do things differently. Both working on their own and in partnership with other councils and organisations, councils have again and again demonstrated their ability to do things differently, save money and improve the services that our residents rely on. For example, there are at least 416 shared service agreements across England, resulting in £462 million of efficiency savings.

Through its proposals on devolution in England, the Government has already recognised that local government has the capacity to lead public service improvement and enhance national prosperity. Residents are confident that local government can take on this challenge, with more than seven out of 10 people saying they trust councils most to decide how services are provided in their area.¹⁵

Councils are thinking creatively about their new public health responsibilities and asking the really important question: how do we use all of our resources – not just a modest ring fenced budget – to improve the health of our residents? In that light, councils are thinking how they affect the wider determinants of health as we seek to make improving the public's health everyone's business. In local government we are asking difficult questions about established ways of working and drawing on years of experience of delivering better outcomes with less money. Where services are not delivering value they will be decommissioned and replaced by services that can deliver on our huge ambitions for local people

The track record is strong. Councils have played a transformative role through Community Budget pilots, Troubled Families and the Better Care Fund (BCF). Modelling by EY showed that adopting the lessons of Community Budget pilots in all local areas could save between £9.4 billion and £20.6 billion over five years across local and central government¹⁶ Other commentators tend to agree – for example, Sir John Peace's Non-Metropolitan Commission identified £12 billion savings to the taxpayers arising from a locally led, more joined-up way of working across the public sector.¹⁷

The introduction of the BCF marked a significant change in how health and care interact with place, with residents being placed at the heart of the change. The fact that the nationally set £3.8 billion BCF was increased by an additional £1.5 billion from local health and care budgets shows areas are ready to take charge of their affairs. Expected savings to the NHS and councils are estimated at £500 million this year alone – almost 10 per cent of the upfront investment.

The sustainability of the NHS and adult social care depends on our collective ability to understand 'what works' to address the public health challenges and then to implement these new models rapidly and at scale. Identifying best practice and spreading it will be critical over the next few years.

¹⁵ Polling on resident satisfaction with councils, LGA, February 2015

¹⁶ Creating a better care system, June 2015

¹⁷ Devolution to Non-Metropolitan England, Non-Metropolitan Commission, March 2015

“Prevention has not enjoyed parity with NHS treatment, despite repeated attempts by central government to prioritise it. Public health funds have too often been raided at times of pressure in acute NHS services and short-term crises.”

Healthy Lives, Healthy People: Our strategy for public health in England 2010



Case study
Bury Metropolitan Borough Council

To illustrate the costs and benefits of public health interventions, NICE ran an analysis with Bury Metropolitan Borough Council to assess its range of smoking interventions using a dedicated tobacco return on investment tool.

Smoking rates in the Lancashire town are slightly above the national average, at 23 per cent. It is estimated that smoking costs the town £10.7 million a year once the cost to the local economy and NHS is taken into account.

The analysis showed that investment of just over £750,000 in smoking interventions for one year leads to a return of 63p over two years, £1.46 over five, £2.82 over 10 and £9.35 over a lifetime.



Case study
Birmingham City Council

Be Active is Birmingham City Council's scheme to provide free leisure services to its residents.

Participants register and are given a card which allows them to use a range of facilities from swimming pools and gyms to exercise classes and badminton courts for free during certain times. A third of the local population has got involved since the project was launched in 2008.

To help it build a business case the council asked Birmingham University to evaluate the project. The research showed that three quarters of users were not previously members of a leisure centre, gym or swimming pool and half were overweight or obese. It also had a knock-on effect in other areas with rises seen in the numbers seeking help over smoking and alcohol.

Overall, for every £1 spent on the scheme £20.69 is estimated to have been recouped in health benefits. This has helped the team behind the project put the case for its continued funding.

We recognise that providing additional financial support is exceptionally challenging, especially given the financial pressures across the public sector. However, the alternative is that without resources specifically for primary and secondary prevention, there is a risk that we won't see the radical step change required to reduce impacts on the NHS and adult social care.

The Government should introduce a Prevention Transformation Fund, worth at least £2 billion annually. This would enable some double running of new investment in preventative services alongside 'business as usual' in the current system, until savings can be realised and reinvested into the system – as part of wider local prevention strategies. This Transformation Fund for prevention should sit alongside both additional and similar transformation funding for the NHS.

We need to shift from a service that reacts when people have acute need to one which focuses on prevention to reduce demand for acute services. An additional fund is necessary to provide a stable funding environment for existing services to make the shift to a system geared more towards prevention – which would include easing the transition from hospital to community-based services.

There is general recognition of the benefits of prevention – and it is now codified in the Care Act – but nothing has really been done previously at scale. This fact is an argument for localising the approach; with little national-level evidence, local areas – with strong local governance and management of risk – should deliver the change that is needed.

To ensure that prevention programmes are delivering results – including reduced acute activity – they need to be monitored regularly with a mixture of process and outcome measures. Innovative approaches should be implemented with an evaluation method in mind from the start. Local authorities need the intelligence to assess whether prevention programmes are working, allowing them to act decisively if they are not.

While local government already receive funding for public health interventions and social care, and they have the freedom in principle to spend other sources of income on these types of initiatives, they cannot do it at the scale required. This is because on average 57 per cent of the public health grant is taken up by costly demand led treatment services (drug, alcohol and sexual health services), and the wider pressures on local government budgets are well known. It is also difficult for local authorities to build a business case to invest their scarce resources in initiatives where the financial benefits accrue to other agencies such as the NHS or the benefits system, or where the financial return won't be realised for many years.

The LGA has consistently argued that a bigger and better BCF needs to be accompanied by a separate transformation fund with the aim of implementing new prevention strategies that drive real change.

Implementation

Despite the wealth of evidence available about the impact or potential impact of preventative approaches on people's health, there is a severe lack of robust studies to show that real savings can be made in public services. This paper takes the best studies available and considers – based on conservative assumptions - how we could make a reality of a preventative approach on a national scale through careful and considered local leadership and delivery.

This is not a panacea. Service delivery and transformation are difficult, and doing it well requires careful planning, skilled workforces, good management, leadership and delivery. Local government has a strong track record in this area and is best placed to lead a step change in our approach to preventative public services – taking account of the evidence, the needs of local people, existing local provision to avoid duplication or waste, and the opportunities that exist to build on existing local priorities.

But this isn't easy – evidence from implementation science shows that it is often difficult to duplicate the positive results from one study when the same thing is tried elsewhere. It requires great skill and judgment to ensure better outcomes and real savings can both be delivered. Many of the savings identified are costs averted rather than being easily 'cashable'. And as a nation, we need to get much better at evaluating and learning in real time, to ensure we can understand and prove what really works. We therefore propose that a key element of the new investment must be a proper evaluation strategy to ensure that costs, benefits and savings are fully tracked and the learning shared widely.

How would the Prevention Transformation Fund work and what would it cover?

The LGA has created a prevention spending model (PSM) that looks at how much money could be saved if authorities were able to invest in activities that improve health outcomes. These encompass a mix of primary prevention, early detection and secondary prevention activities. The strategic approach is to ensure that every Prevention Transformation Fund pound spent attains the greatest possible outcome – and specifically, outcomes which directly reduce costs to public services.

Methodology

In order to achieve this, the LGA reviewed an extensive range of intervention case studies that had provided a net cost benefit. There were two types of case study. The first were models developed to explore potential savings that an intervention could in theory generate. The second were evaluations of interventions that had been undertaken in a real-life setting (intervention evaluations). For the purposes of our model all, except one, of the case studies included were intervention evaluations, where the cost benefits associated with the intervention were grounded in real experience. The only model included was written by NICE.

While intervention evaluations were used, the cost benefit element was sometimes based on a model. The models varied, but had generally been devised by respected agencies and organisations such as the Department for Communities and Local Government (DCLG), Matrix Insight (commissioned by Health England) and the Chartered Institute of Environmental Health (CIEH).

The case studies reviewed were delivered by a range of service providers, from local authorities and the NHS to voluntary organisations and charities. Case studies were only included if they were delivered in part or in full by a local authority.

That said, the resulting cost benefits are delivered to a wider audience, including to the NHS and the Department for Work and Pensions (DWP). All of the interventions are of benefit to the individual, whether it is improved mental and physical health, or quality of life, however these benefits are not included within the model unless they have been monetarised or have a cost impact on the provision of a service.

The case studies included in the PSM had varying time frames but all generated net benefits within five years. Some required a single year of investment, but generated cost savings for up to five years; others were, for example, a two year intervention which delivered cost benefits within the same time frame. Because of the underlying calculations used by each of the models, it was not possible to present the case studies within a single time frame; however time frames are included against each case study within the model.

Case studies that were for a single authority area were scaled to estimate the costs and potential savings if applied in every local authority. Case studies that looked at prevention spending for a proportion of the population (for example, the Matrix reviews) were applied to national population figures.

While the case studies were scaled to a national level, it does not imply that projects reach all of the target populations.

For example, one service worked to upgrade housing that was found not to be decent, the authority assisted 19,342 households, but they identified an additional 45,000 that would also benefit from the scheme (Birmingham Decent Homes). Therefore, when applied to a national level, the programme would, in theory assist around 19,000 households in each authority area, but not all households that would benefit.

The key points from the PSM are:

- 11 case studies were included in the PSM
- the total cost for implementing all 11 nationally would be £17 billion
- the cost benefit ratio varied between case studies, and ranged from as little as a net saving of £0.003 per £1 spent to as much as £20.69 per £1
- a further £2 billion of savings were also identified, these are not included in the net savings as they were benefits relating to other groups, such as children and young people
- the model has taken a cautious approach, scaling down the proposed interventions to take account of the fact that not all of them will necessarily be appropriate everywhere, and that £17 billion is unlikely to be available and there would be a need to prioritise more productive interventions tailored to local patterns of need and existing provision
- if the evaluated results were repeated in other areas, £1bn spent on the 11 combined schemes could yield a return in savings of £1.90 for every £1 spent over a five year period
- we wanted to focus on the savings which could be delivered to public services. As a result, the financial return of 90 per cent set out above excludes health benefits to individuals.

Explanation of the cost benefit ratio

The PSM identified 11 case studies, delivered in full or in part by local authorities, which demonstrated that an investment in activities to prevent ill-health or improve health outcomes can deliver savings (either to local authorities or to other sectors).

Each case study, however, has its own cost benefit ratio: for example, one intervention has a return of £20.69 per £1 invested (Be Active Birmingham), while another has a net return of £0.003 per £1 invested (Carers with Depression). Table 1 below shows the cost benefit per case study. All case studies have been included, even if they have a low return, this is because the model is outcome focused, rather than output focused and considers the differences actions and activities can make in people's lives.

We have included a project on carer depression not because this evaluation shows a significant financial benefit, but because it showed significant positive effects for carers which help them to continue caring. No analysis has been undertaken of how many of the carers in this project might have had to give up their caring role without this support. Given the very large number of carers who give up a great deal of time to keep their loved ones at home, and the fact that our health and social care systems rely on the work of family carers to support millions of people, we think the wider benefits of this project deserve further study and development. We have therefore included it in the suite of programmes to be considered.



Table 1: Cost benefit ratio by intervention

Name of intervention	Cost benefit (per £1)	Time frame for investment	Time frame for return	Intervention Area
Be Active: 40-65 year olds	£20.69	5 years	5 years	Health
Glasgow Health Walks	£7.90	1 year	5 years	Physical and mental health
Incredible Years Programme: Adult Benefits	£3.12	1 year	1 year	Parental depression
Telehealth Care	£2.68	1 year	1 year	Independent living for people with learning difficulties
Link Age Plus: 50+ Employment	£1.95	2 years	2 years	Employment 50+
NICE: Tobacco Harm Reduction	£1.46	2 years	5 years	Reduction in smoking
POPP: Partnership for Older People Projects	£1.20	3 years	3 years	Older people: saving in emergency bed days and additional service benefit from addressing older people's presenting needs
Handyman	£1.13	2 years	2 years	Independent living for older, disabled and vulnerable people
Decent / Warmer Homes	£0.98	1 year	1 year	Housing
Kent Supported Employment	£0.49	1 year	1 year	Employment: mental and physical
Matrix: Carer Depression	£0.003*	1 year	Between 1 and 5 years	Carers

*This only includes the savings made in prescriptions and does not quantify the savings made to from carers being able to continue caring.

Nationally funded, intervention programmes would be commissioned locally. The selection of prevention projects would vary in each authority area depending on the local context and demographic pressures, therefore the cost benefit ratio would also vary.

If each project identified were implemented nationally the 11 interventions would require an investment of around £17 billion. For illustrative purposes, Table 2 opposite shows how £1 billion of a £2 billion Prevention Transformation Fund could be spent across the 11 projects to generate benefits of £7.19 billion over a five year period. Of this, £1.90 billion are financial savings and the rest are health benefits to individuals. This suggests a financial return over five years of 90 per cent.

However, we do not propose a 'national' model – there must be local flexibility over how to allocate the funds to best meet local needs. Savings generated would therefore vary depending on the level of investment which would be dependent on local contexts and pressures.



Table 2: Potential cost benefits of a £1bn investment as part of a national Prevention Transformation Fund

Intervention Area	Intervention spend	Total benefit	Of which, savings
Glasgow Health Walks	£1,000,000	£7,897,117	£7,000,000
NICE: Tobacco harm reduction	£50,000,000	£73,000,000	£73,000,000
Handyman	£19,000,000	£21,508,000	£19,704,041
POPP: Partnership for Older People Projects	£200,000,000	£240,000,000	£240,000,000
Link Age Plus: 50+ Employment	£50,000,000	£97,461,538	£97,461,538
Telehealth Care	£20,000,000	£53,564,000	£53,564,000
Matrix: Carer depression	£100,000,000	£269,865	Up to £269,865*
Incredible Years Programme: Adult benefits	£108,000,000	£337,073,684	£337,073,684
Be Active: 40-65 year olds.	£300,000,000	£6,207,272,727	£930,000,000
Decent / Warmer homes	£150,000,000	£146,832,994	£146,832,994
Kent Supported Employment	£2,000,000	£979,617	£979,617
Combined costs	£1,000,000,000	£7,185,859,543	£1,905,885,740

*Unable to separate QALYs from cost benefit.

Table 3: Summary of Interventions

Walk Glasgow

Delivered by: LA, NHS, Other

Savings to: LA, NHS

'Walk Glasgow', a partnership project funded by Glasgow Life, NHS Greater Glasgow and Clyde and Paths for All. The purpose of the project is to, 'Develop and promote walking opportunities across Glasgow, targeting groups least likely to take regular exercise, in order to increase physical activity levels and improve the health and wellbeing of city residents'.

Glasgow Health Walks consisted of open walking groups that were delivered on a weekly basis and closed walking groups that met at frequent intervals. Open walks, are open to all and consist of led walks at an easy pace which last about an hour. Open walks are run by volunteer walk leaders who are unpaid and are usually recruited from the walkers in the group. Closed walks are restricted to certain groups of participants. Each walk is targeted at a particular client group eg hospital in-patients, people with learning disabilities, members of ethnic minorities and individuals referred by medical practitioners. The majority of walks support individuals who have experienced mental or physical challenges. Where appropriate, participants in closed walks are encouraged and supported to move onto open walks as their personal confidence and abilities increase.

Walkers and walk leaders are fitter and have improved physical health as a result of becoming more regularly physically active, have more social contacts and are more confident, experience less isolation and take part in new experiences. Walkers feel safe and comfortable and are able to take part in outdoor physical activity in their local green space by being part of a group, and can participate in a supported programme that encourages them to progress and to achieve a greater sense of personal satisfaction. They are able to interact with others from different cultural and social backgrounds and to gain a better understanding of ethnicity and disability. Walk leaders have improved self-esteem and a sense of worth as they feel valued by the community and they are able to gain new practical and social skills.

www.pathsforall.org.uk/component/option,com_docman/Itemid,69/gid,774/task,doc_download/

Smoking Cessation – Bury Metropolitan Borough Council

Delivered by: LA

Savings to: LA, NHS, Other (business/economy)

To illustrate the costs of smoking – and the savings that can be achieved by tackling tobacco use, NICE ran an analysis for Bury Metropolitan Borough Council using NICE's return on investment tobacco model. This is the only case study which is a model and not an intervention evaluation. This tool was developed to help local decision-making on tobacco control. Bury has an adult population of around 141,000. Roughly 23 per cent smoke and 33 per cent are ex-smokers.

The model estimated the total annual cost of smoking at £10.7 million, broken down as follows: business – £3.7 million; NHS – £6.8 million; second-hand smoke – £110,000. Investing £751,692 in smoking cessation interventions for one year (equivalent to current practice) would achieve estimated gross savings of £321,579 overall in the first two years (this does not include the cost of implementation).

The model consists of a range of smoking cessation interventions.

www.nice.org.uk/advice/lgb10/chapter/Judging-the-cost-effectiveness-of-public-health-activities

Handyperson Programme

Delivered by: LA

Savings to: LA, NHS, Other

Evaluation of the Handyperson Programme has shown that handyperson services are assisting large numbers of older, disabled and vulnerable people to live independently in their own homes for longer, in greater levels of comfort and security. They offer an important safety net for older people, and they also enhance the effectiveness of health and social care provision through the delivery of often very simple and very low cost interventions. Services are consistently highly rated by people who use them, and they are valued for their trustworthiness, reliability, quality, and crucially for the skills and respectful attitudes of the staff. As the population ages there will be greater demand for such services, and a greater imperative to assist older people to live independently. Handyperson services can and do support the preventive agenda.

- small repairs and minor adaptations that reduce the risk of falls and enable independent living
- home security measures that prevent burglaries and maintain independent living
- hospital discharge schemes (where they include hazard management and equipment installation) that reduce the risk of falls, maintain independent living and reduce length of hospital stays
- fire safety checks and installation of alarms and smoke detectors that reduce death and injury caused by fires
- energy efficiency checks that reduce excess winter deaths and expenditure on fuel, where a check leads to an intervention to improve heating or warmth in a home.

The Handyperson Financial Benefits Toolkit has been designed to allow handyperson services to estimate the social benefits that services deliver and assists with the development of business cases.

www.communities.gov.uk/publications/housing/financialbenefitstoolkit

Partnerships for Older People Projects (POPP)

Delivered by: LA, NHS, Other

Savings to: LA, NHS

The Partnerships for Older People Projects (POPP) programme was an ambitious initiative designed to increase our learning about how to promote older people's independence, particularly through joint approaches to reducing reliance on long-term institutional care and acute hospital admissions.

The learning from this programme has increased the evidence base about the benefits of prevention, early intervention and the integration of services – all fundamental underpinning principles to the reform of the care and support system and our vision to create a National Care Service.

Of the 146 projects, two-thirds were primarily directed at reducing social isolation and exclusion or promoting healthy living among older people ('community facing'). The remaining one-third focused primarily on avoiding hospital admission or facilitating early discharge from acute or institutional care ('hospital facing'). Some addressed the full spectrum of needs. In addition to these 'core' projects, a further 530 small 'upstream' projects were commissioned from the third sector.

www.pssru.ac.uk/pdf/rs053.pdf

LinkAge Plus

Delivered by: LA, NHS, Other

Savings to: LA, Other

Around £10 million was invested by the Department for Work and Pensions (DWP) in LinkAge Plus over a two-year period in eight pilot areas. Each pilot area spent the money in different ways and there were over a hundred individual initiatives across the eight areas.

In Lancaster the pilot set out to 'make a difference' to the lives of older people in Lancaster by developing projects that were beneficial to Lancaster's older population; and which could be embedded and sustained in the future. The aims of the projects were as follows:

- Access to Information: to provide residents with direct access to information and support relevant to people over 50, whether it be for them or for an elderly relative.
- Care Navigator Service: to work on a one-to-one basis to provide practical support to enable vulnerable and isolated older people to access services and support that they need to help them remain active and to play a part within their communities.
- Employment Service and Volunteer Bureau: to engage with, and provide tailored support to, people who were interested in volunteering and returning to work/ finding new employment opportunities. It was envisaged that the project would work with Jobcentre Plus and also engage with local employers.

Associated with the Employment Service and Volunteer Bureau was the Time Banks project, which aimed to identify how local residents could provide services to support one another.

www.gov.uk/government/publications/linkage-plus-national-evaluation-reports

Telehealth care

Delivered by: LA, NHS

Savings to: LA

NHS/DH revenue funding was allocated to five regional projects to promote joint working across social care and health. The objective was to deliver cashable savings by embedding telecare as part of mainstream pathways. The selected projects covered the three areas specified in the selection criteria as a priority; people with learning disabilities and people living with dementia and other long-term conditions.

The total regional net return on investment (ROI) is predicted using mietool to be £708,122 by the end of 2011/12, with a forecast of £3 million over the five year period.

Focused on people with learning disabilities, throughout Lincolnshire, living in their own tenancies within CSL provision. Research had identified that many companies within the county were providing waking night services in people's homes which were traditional rather than necessary services. With the introduction of Telecare these could change to sleep in provision, or be removed completely.

www.thinklocalactpersonal.org.uk/Regions/EastMidlands/AssistiveTech/?parent=8150&child=9056

Assessment and support of caregivers for preventing depression in caregivers (of adults with dementia)

Delivered by: LA

Savings to: LA, NHS

A full year of day care support (two days per week) for caregivers to reduce symptoms of depression compared to no day care support (Zarit, 1998) in a UK setting.

Compared to no day care support, a full year of day care support decreases the percentage of caregivers with depression from 50 per cent to 36 per cent. This effect was obtained from a review undertaken to identify evidence on the effectiveness and cost-effectiveness of assessment and support of caregivers to prevent depression.

Benefits: The benefits of the intervention derive from decreased levels of depression in caregivers. Two types of benefits are considered: QALYs and health care cost savings. Based on the Quality-Adjusted Life Years (QALY) gained and the health care cost savings of reducing the probability of having depression, a decrease in the percentage of caregivers with depression from 50 per cent to 36 per cent is associated with the following benefits:

- an additional 0.19 QALYs per person
- cost savings of £18 per person (£2007/08).

<http://help.matrixknowledge.com/interventions/docs/HE%20Intervention%20Report%209.pdf>

Incredible Years: Manchester Child and Parents Service

Delivered by: LA, NHS

Savings to: LA: adult and children's service, NHS, Other (police and housing)

CAPS delivered 95 effective, evidence based parent courses to approximately 760 parents of 0-12 year olds showing clinically significant improvements in both child behaviour and parental depression and stress.

Data demonstrates that CAPS engages some of the most vulnerable families in the city with approximately 68 per cent of families falling into clinical ranges for problem behaviour and depression; 51 per cent having three or more risk factors and 94 per cent having one or more risk factor for poor child outcome.

- Clinically significant improvements to child outcomes have been demonstrated including increased school attendance and attainment. Of those with persistent absences at pre course 75 per cent were no longer persistently absent one term after completing the course.
- Calculations suggest substantial efficiency savings as a result of early intervention in Manchester. As an absolute minimum, the cost saving of family support and mental health input alone approximates to £6000 per family over a year for those families who have moved out of clinical ranges for problem behaviour and depression following CAPS intervention. This represents a potential cost saving of £3,558,000 (593 course completers no longer in clinical range post course x £6000)
- Within three months of completing a CAPS parent course 40 per cent of parents were either employed or reported seeking employment

www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&uact=8&ved=0CCQQFjAA&url=http%3A%2F%2Fincredibleyear

Be Active

Delivered by: LA, NHS

Savings to: LA, NHS, Other

Be Active is a scheme provided free of charge to all Birmingham residents who live within the Birmingham City Council area. The aim of the scheme is to tackle health inequality and associated deprivation levels, by offering access to free physical activity sessions for all 1.1 million citizens of the city. Participants can take part in free swimming, exercise classes or the gym at any council-run leisure centre during off-peak hours, which vary according to each centre and some community based.

It is estimated that Be Active has nearly 140,000 active users per year. Over five years, the aggregate cost is estimated at £22 million. The benefits generated by the scheme exceed its cost by £445.2 million. This net benefit includes 'cash savings' (£28.7 million), cost savings and productivity gains to the public and private sector (£39.2 million), and improvements in quality of life (to the equivalent of £377.2 million).

When analysed per person, the benefits over the lifetime of an individual exceed the cost of the scheme by £3,202.7 per person.

Every £1 invested in Be Active generates on average £21.30 in benefits. The returns vary for the different stakeholders, depending on the amount of costs incurred and benefits received:

For every £1 spent on Be Active the return for the local NHS is £22.80 in terms of health care related benefits (primary and secondary care). The majority of these benefits relate to health-related quality of life gains. A smaller amount relates to health care cost savings (£2.60) – £0.50 are estimated to be cashable as medication cost savings.

For every £1 spent on Be Active the return for the Local Authority is £2.30 in terms of improvements in quality of life among its residents. Both employers and the Treasury benefits from the scheme without incurring in any cost.

www.socialfinance.org.uk/wp-content/uploads/2014/11/matrix_be_active_final_report_0.pdf

Decent Homes

Delivered by: LA

Savings to: LA, NHS

Birmingham's Decent Homes programme has had a major impact on the health and quality of life of tenants. It has reduced housing related risk which can exacerbate heart and respiratory disease, reduced accidents in the home and given greater home security and mental well-being.

By 30 September 2010, the city had made 162,000 improvements to drive up standards of decency in the Council's stock. To date total expenditure on upgrading City Council stock is £700m.

This projects looks at improving private sector homes.

Model uses CIEH Housing Health and Safety Rating System (HHSRS) Costs Calculator, to estimate (median) indicative annual cost and savings for the NHS in Birmingham.

www.gov.uk/government/uploads/system/uploads/attachment_data/file/356051/Briefing9_Economics_of_investments_health_inequalities

Kent Supported Employment

Delivered by: LA

Savings to: LA, Other

This report summarises the first phase of a three phase study to develop a financial cost: benefit analysis specific to supported employment for people with learning disabilities. It is being conducted in collaboration with Kent Supported Employment Agency (KSE). It aims to develop a cost benefit framework that is robust enough to accurately identify the potential costs and savings to the local authority and taxpayer of delivering the KSE service. Phase 1 ran from January to March 2010 and involved developing the cost benefit framework and collecting the relevant information from KSE.

The results showed that in the period March 2009 to February 2010 KSE supported 118 people in paid jobs, 57 of whom were employees with learning disabilities. The remainder were mainly people with mental health issues, severe physical disabilities and autism. All had been identified as requiring specialist employment provision. KSE had 37 front line staff, with three jobs supported per staff member. The jobs, represented a cross-section of public (32 per cent of jobs), private (54 per cent) and third sector (14 per cent) employees, which on average pay above the national minimum wage rates.

https://shareweb.kent.gov.uk/Documents/adult-Social-Services/kent-supported-employment/kse_financial_costs_report.pdf

Annexes

The Billion Pound Allocation

	Full national cost £000s	Full cost benefit ratio	Financial cost benefit ratio	Proposed Spend £000s	Financial Savings £000s	Overall benefits £000s
Glasgow Health Walks	17,054,830	7.90	7.00	1,000,000	1,905,886	7,185,860
NICE: Tobacco harm reduction	459,467	1.46	1.46	1,000	7,000	7,897
Handyman	19,000	1.13	1.04	50,000	73,000	73,000
POPP: Partnership for Older People Projects	314,483	1.20	1.20	19,000	19,704	21,508
Link Age Plus: 50+ Employment	106,556	1.95	1.95	200,000	240,000	240,000
Telecare	21,100	2.68	2.68	50,000	97,462	97,462
Matrix: Carer depression	9,463,655	0.003	0.003	20,000	53,564	53,564
Incredible Years Programme: Adult benefits	173,280	0.003	0.003	100,000	270	270
BeActive: 40-65 year olds	4,642,000	3.12	3.12	108,000	337,074	337,074
Decent / Warmer homes	1,845,796	20.69	3.10	300,000	930,000	6,207,273
Kent Supported Employment	2,091	0.98	0.98	150,000	146,833	146,833
		0.49	0.49	2,000	980	980

Name of intervention	Intervention Area	Time Frame		Delivered by				Savings to			
		Investment	Return	Local Authority	NHS	Voluntary	Other	Local Authority	NHS	Other	
Glasgow Health Walks	Physical and mental health	1 year	Up to 5 years	Y	Y	Y		Y	Y		
NICE: Tobacco harm reduction	Reduction in smoking	2 years	5 years	Y				Y	Y	Y	
Handyman	Independent living	2 years	2 years	Y				Y	Y	Y	
POPP: Partnership for Older People Projects	Older people	3 years	3 years	Y			Y	Y	Y		
Link Age Plus: 50+ Employment	Employment 50+	2 years	2 years	Y			Y	Y	Y		Y
Telecare	Independent living	1 year	1 year (annual savings)	Y			Y				
Matrix: Carer Depression	Carers	1 year	Between 1 and 5 years	Y			Y	Y	Y		
Incredible Years Programme: Adult Benefits	Parental depression	1 year	1 year	Y			Y	Y	Y		Y
BeActive: 40-65 year olds	Health	5 years	5 years	Y			Y	Y	Y		Y
Decent / Warmer Homes	Housing	1 year	1 year	Y			Y		Y		
Kent Supported Employment	Employment	1 year	1 year	Y			Y				Y



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